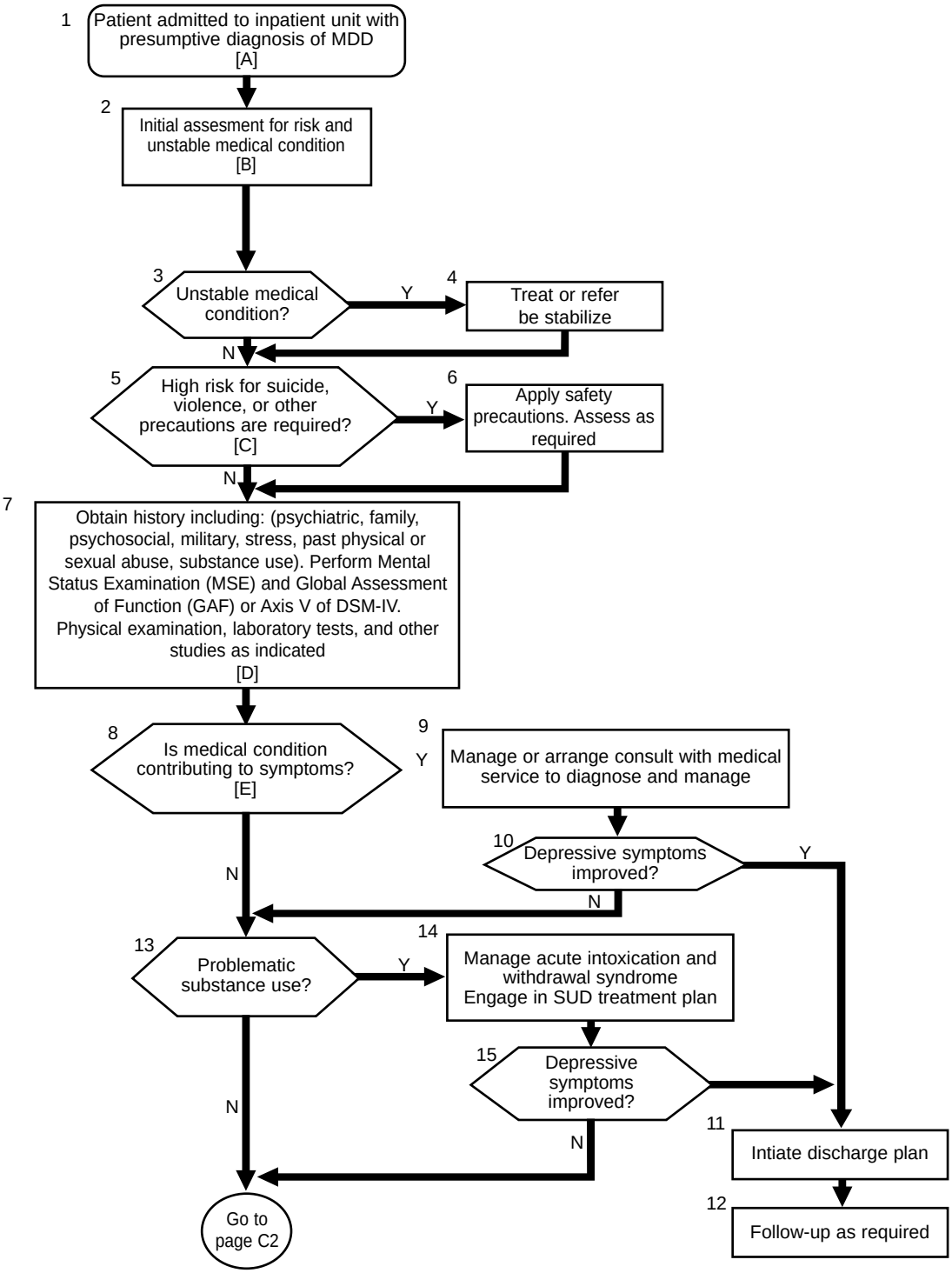
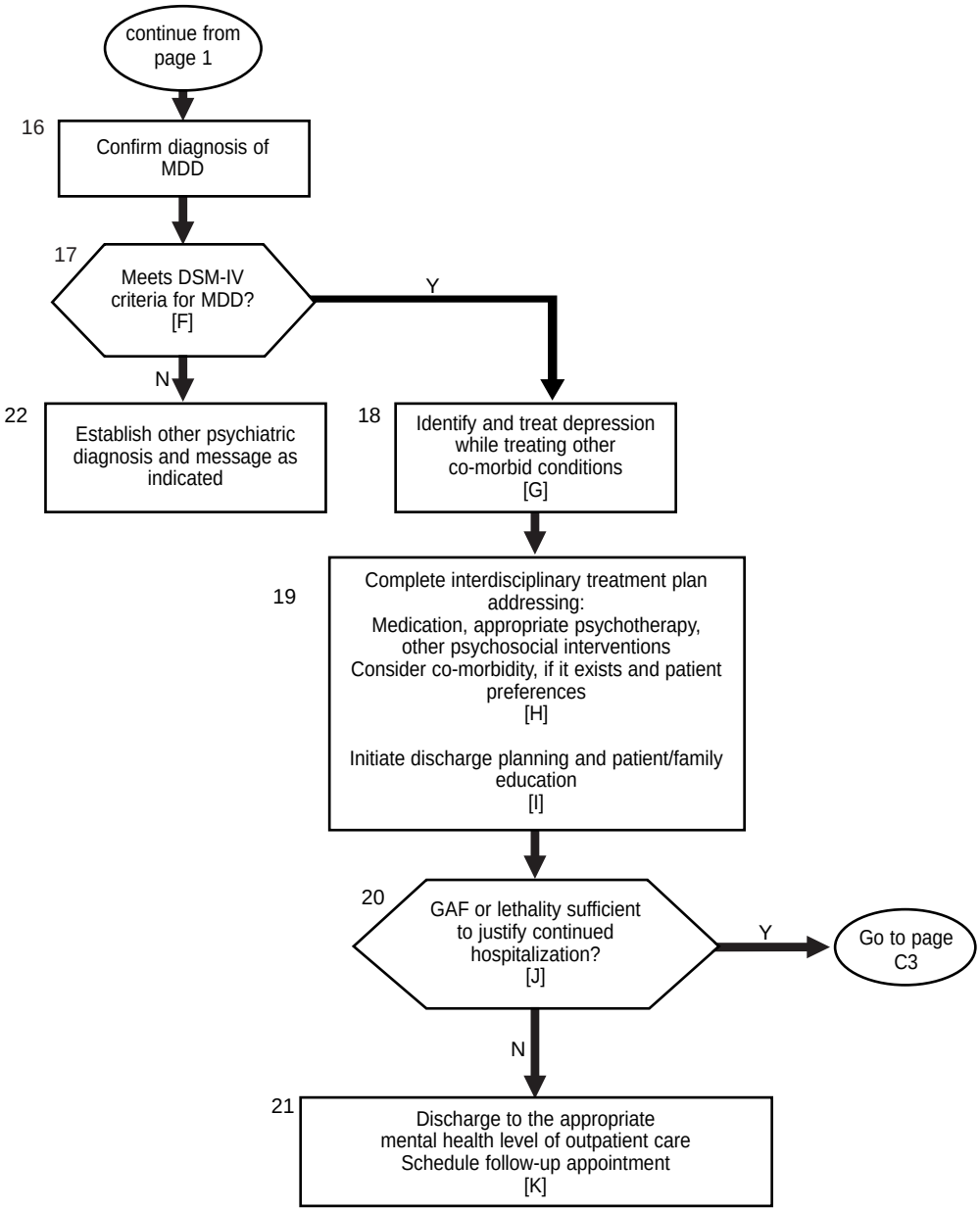
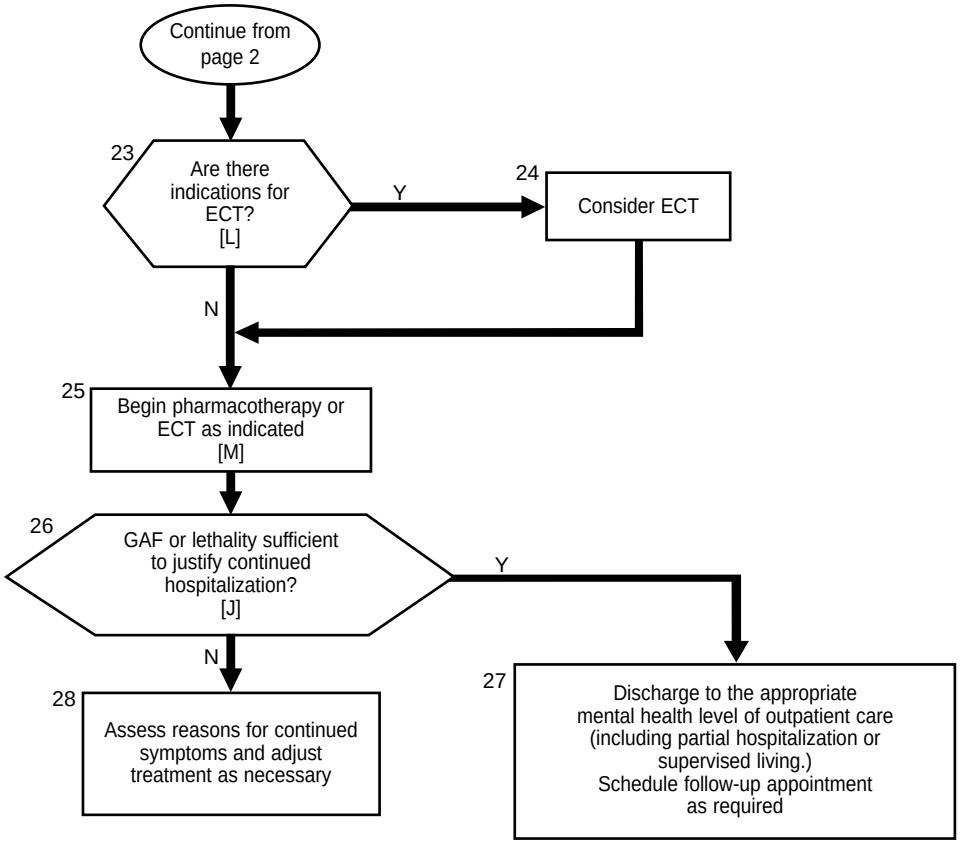
Guideline Summary




continue from page 1
16
Confirm diagnosis of MDD
17
Meets DSM-IV criteria for MDD? [F]
Y
N
22
Establish other psychiatric diagnosis and message as indicated
18
Identify and treat depression while treating other co-morbid conditions [G]
19
Complete interdisciplinary treatment plan addressing:
Medication, appropriate psychotherapy, other psychosocial interventions
Consider co-morbidity, if it exists and patient preferences
[H]
Initiate discharge planning and patient/family education
[I]
20
GAF or lethality sufficient to justify continued hospitalization? [J]
Y
Go to page C3
N
21
Discharge to the appropriate mental health level of outpatient care
Schedule follow-up appointment
[K]



VA access to full guidelines: http://www.oqp.med.va.gov/cpg/cpg.htm

DoD access to full guidelines: http://www.cs.amedd.army.mil/Qmo

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November 2001

MDD Inpatient Care Guideline Summary

A. Executive Summary.

The primary objectives in inpatient psychiatric management of Major Depressive Disorder are:

*Immediate stabilization/treatment of behavioral or medical emergencies

*Assessment and treatment of medical conditions or substance use disorders which may cause depression

*Establishment of DSM-IV diagnosis of MDD and institution of intensive treatment, including pharmacotherapy, adjunctive therapy, and ECT, where appropriate.

*Once effective symptom control has been achieved, outpatient follow-up should be scheduled as recommended in the specialty outpatient mental health module.

B. Behavioral Risk Factors

1) Violence: The following situations may serve as warning signs of potential violent behavior:

*Ideation and/or intent to harm others.

*Past history of violent behavior

*Severely agitated or hostile behavior

*Actively psychotic symptoms

2) Suicide: Indicators of immediate risk for suicidal behavior include:

*Current suicidal ideas/plans

*Active mental illness (depression or psychosis)

*Substance use disorder

*Past history of suicide acts

*Formulation of a suicidal plan

*Availability of a means

*Disruption of important personal relationship

*Failure at important personal endeavors

C. Medical Conditions Related to Depression

Pathology	Disease
Cardio/vascular	Coronary artery disease, Congestive heart failure, Uncontrolled hypertension, Anemia, Stroke, Vascular Dementias
Chronic Pain Syndrome	Fibromyalgia, Reflex sympathetic dystrophy, Low back pain (LBP), Chronic pelvic pain, Bone or disease related pain
Degenerative	Presbyopia, Presbycusis, Alzheimer's disease, Parkinson's disease, Huntington's disease, Other Neurodegenerative diseases
Immune	HIV (both primary and infection-related), Multiple Sclerosis, Systemic Lupus Erythematosis (SLE), Sarcoidosis
Infection	Systemic Inflammatory Response Syndrome (SIRS), Meningitis
Metabolic/Endocrine Conditions (include renal and pulmonary)	Malnutrition, Vitamin deficiencies, Hypo/Hyperthyroidism, Addison's Disease, Diabetes Mellitus, Hepatic disease (cirrhosis), Electrolyte disturbances, Acidbase disturbances, Chronic Obstructive Pulmonary Disease (COPD) or Asthma, Hypoxia
Neoplasm	Of any kind, especially pancreatic or central nervous system (CNS)

D. Medications That Can Cause Depression

Evidence

QE	SR	Drug/Drug Class
I	B	Amphetamine withdrawal, Anabolic Steroids, Digitalis, Glucocorticoids
I	C	Cocaine withdrawal
II-1	C	Reserpine
II-2	A	Gonadotropin-releasing agonists, Pimozide
II-2	B	Propanolol (Beta Blockers)
II-2	C	ACE inhibitors, Antihyperlipidemics, Benzodiazepines, Cimetidine, Ranitidine, Clonidine, Cycloserine, Interferons, Levodopa, Methyldopa, Metoclopramide, Oral contraceptives, Topiramate, Verapamil (Calcium channel Blockers)

E. Criteria For Inpatient Admission

Admission is indicated if criterion in section A is met and B or C or D is met.
A. A DSM-IV diagnosis or diagnoses are present and complete on all 5 axes and there is evidence of significant associated social impairment, occupational impairment or subjective suffering.
B. The patient is a danger to him/herself such as might be indicated by one or more of the following:
• High lethality or high-intent suicide attempt in past two weeks
• Recent suicide gesture in patient with history of high lethality or high intent suicide attempts
• Suicidal ideation with a plan, in the presence of command hallucinations, delusions of guilt or impending death, intractable pain, feelings of depression or hopelessness or other known precipitant of suicide
• Persistent acts of self-mutilation
• Medical emergencies influenced by mental illness
• Inability to provide for own basic needs of food, shelter or medical care as the result of a mental illness
• Bizarre behavior due to a psychotic disorder that endangers patient, his/her reputation, assets or relationships
C. The patient is a danger to others as a result of a mental disorder that is likely to improve by hospitalization, as evidenced by one or more of the following:
• Threats of harm against a specific individual associated with a delusional thought pattern or persistent anger/agitation
• Threats of harm against an unidentified person(s)
• Threatening behavior with a lethal weapon or possession of a lethal weapon in a state of emotional disturbance
• Escalating threatening language or behavior in a patient with a history of assaultive or aggressive behavior
• Significant damage to property
D. The patient has a serious mental disorder causing significant impairment of social, familial, vocational or educational functioning that would benefit from the intensity of acute treatment, such as:
• Depressed mood with disabling vegetative symptoms
• Marked deterioration in personal hygiene as a result of an acute psychiatric disorder
• Complete withdrawal from work, school or social situations due to an acute psychiatric disorder

• Adequate trial of outpatient treatment resulting in failure. Examples of outpatient failures are:
* non-compliance with treatment as a complication of affective or psychotic disorder
* socially disruptive behavior that alienates the social support necessary for outpatient treatment success
* severe primary psychiatric illness worsened by substance abuse
* unstable, unsupportive or hostile living situation that significantly interferes with outpatient treatment success
* medical condition or physical disability that prevents regular participation in outpatient treatment

F. DSM-IV - COMMON MOOD DISORDERS (not inclusive)

D E P R E S S I V E D I S O R D E R S

DSM-IV Code	DIAGNOSIS	DESCRIPTION / CRITERIA
296.2x	**Major Depressive Disorder, Single Episode**	A. Five (or more) of the following symptoms have been present during the same two week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. **Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.** (1) depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (2) markedly diminished interest or pleasure in all, or almost all activities most of the day, nearly every day, as indicated by either subjective account or observation made by others (3) significant weight loss when not dieting or weight gain (a change of more than 5% of body weight in a month), or decrease/increase in appetite nearly every day (4) insomnia or hypersomnia nearly every day (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down) (6) fatigue or loss of energy nearly every day (7) feelings of worthlessness, or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) (8) diminished ability to think or concentrate, or indecisiveness, nearly every day, (either by subjective account or as observed by others) (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide B. The symptoms do not meet criteria for a Mixed Episode. C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. D. The symptoms are not due to the direct physiological effects of a substance (drug of abuse/medication) or a general medical condition (hypothyroidism). E. The symptoms are not better accounted for by Bereavement.
296.3x	**Major Depressive Disorder, Recurrent**	Any condition classifiable as **296.2** that is recurrent. See above description.

DSM-IV Code	DIAGNOSIS	DESCRIPTION / CRITERIA
300.4	**Dysthymic Disorder**	A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least two years. B. Presence, while depressed of two or more of the following: (1) poor appetite or overeating (2) insomnia or hypersomnia (3) low energy or fatigue (4) low self-esteem (5) poor concentration or difficulty making decisions (6) feelings of hopelessness C. During the two year period the person has never been without the symptoms of A or B for more than 2 months at a time. D. No Major Depressive Episode has been present during the first two years of the disturbance; the disturbance is not better accounted for by chronic Major Depressive Disorder or Major Depressive Disorder, in Partial Remission. E. There has never been a Manic Episode, a Mixed Episode or a Hypomanic Episode and criteria has never been met for Cyclothymic D/O. F. Disturbance does not occur exclusively during course of a chronic Psychotic D/O. G. The symptoms are not due to the direct physiological effects of a substance (drug of abuse/medication) or a general medical condition (hypothyroidism). H. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

DSM-IV 5th Digit Subclassification Codes: Add to 296.0 to 296.6 where the "x" is located

0 Unspecified	2 Moderate	4 Severe, with Psychotic Behavior	6 Full Remission
1 Mild	3 Severe, No Psychotic Behavior	5 In Partial or Unspecified Remission	

G. Pharmacologic Treatment of Depression

General Principles of Pharmacotherapy

- No agent has been proven to be superior to another in efficacy or time to response.
- Use what has worked for the patient in the past.
- The most common cause of treatment failure is an inadequate medication trial.
- If no response at 4-6 weeks, consider switching, combining or augmenting the pharmacotherapy.
- SSRIs are agents of first choice due to ease of use, more tolerable side effects and safety in overdose.
- Counsel pregnant women and those considering pregnancy. The potential risks and benefits of pharmacotherapy must be weighed.

Managing Medication Side Effects

- Insomnia - Consider Diphenhydramine at HS or a brief trial of a short-acting non-addictive BZ receptor-binding agent, then reassess.
- Akathisia - Associated with newer antidepressants. Consider adding a small dose of clonazepam (0.5 mg q HS) or propanolol (10-20 mg bid/tid).
- Sexual dysfunction - Common with all SSRIs and others. Bupropion is least likely to produce this side effect.

H. ANTIDEPRESSANT MEDICATION TABLE

Refer to pharmaceutical manufacturer's literature for full prescribing information

SEROTONIN SELECTIVE REUPTAKE INHIBITORS (SSRIs)

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Citalopram	Celexa	20 mg	60 mg	Reduce dose for the elderly & those with renal or hepatic failure	No serious systemic toxicity even after substantial overdose. Drug interactions may include tricyclic antidepressants, carbamazepine & warfarin.	Nausea, insomnia, sedation, headache, fatigue dizziness, sexual dysfunction anorexia, weight loss, sweating, GI distress, tremor, restlessness, agitation, anxiety.	Response rate = 2 - 4 wks	AM daily dosing. Can be started at an effective dose immediately.
Fluoxetine	Prozac	20 mg	80 mg					
Paroxetine	Paxil	20 mg	50 mg					
Sertraline	Zoloft	50 mg	200 mg					
First Line Antidepressant Medication Drugs of this class differ substantially in safety, tolerability and simplicity when used in patients on other medications. Can work in TCA nonresponders. Useful in several anxiety disorders. Taper gradually when discontinuing these medications. Fluoxetine has the longer half-life.								

SEROTONIN and NOREPHINEPHRINE REUPTAKE INHIBITORS (SNRIs)

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Venlafaxine IR	Effexor IR	75 mg	375 mg	Information Not Available	No serious systemic toxicity. Downtaper slowly to prevent clinically significant withdrawal syndrome. Few drug interactions.	Comparable to SSRIs at low dose. Nausea, dry mouth, insomnia, somnolence, dizziness, anxiety, abnormal ejaculation, headache, asthenia, sweating.	Response rate = 2 - 4 wks (4 - 7 days at ~300 mg/day)	BID or TID dosing with IR. Daily dosing with XR. Can be started at an effective dose (75 mg) immediately.
Venlafaxine XR	Effexor XR	75 mg	375 mg					
Dual action drug that predominantly acts like a Serotonin Selective Reuptake inhibitor at low doses and adds the effect of an Norepinephrine Selective Reuptake Inhibitor at high doses. Possible efficacy in cases not responsive to TCAs or SSRIs. Taper dose prior to discontinuation.								

SEROTONIN (5-H2A) RECEPTOR ANTAGONIST and WEAK SEROTONIN REUPTAKE INHIBITORS

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Nefazodone	Serzone	200 mg	600 mg	Reduce dose for the elderly & those with renal or hepatic failure	No serious systemic toxicity from OD. Can interact with agents that decrease arousal/impair cognitive performance and interact with adrenergic agents that regulate blood pressure.	Somnolence dizziness, fatigue, dry mouth, nausea, headache, constipation, impaired vision. Unlikely to cause sexual dysfunction.	Response rate = 2 - 4 wks	BID dosing. Requires dose titration.
Trazodone	Desyrel	150 mg	600 mg					
Corrects sleep disturbance and reduces anxiety in about one week.								

DOPAMINE and NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIs)

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Bupropion - IR	Wellbutrin - IR	200 mg	450 mg	Reduce dose for the elderly & those with renal or hepatic failure	Seizure risk at doses higher than max. Drug/drug interactions uncommon.	Rarely causes sexual dysfunction.	Response rate = 2 - 4 wks	BID / TID dosing. Requires dose titration.
Bupropion - SR	Wellbutrin - SR	150 mg	400 mg					
Least likely antidepressant to result in a pt becoming manic. Do not use if there is a history of seizure disorder, head trauma, bulimia or anorexia. Can work in TCA nonresponders.								

TRICYCLIC ANTIDEPRESSANTS (TCAs) – Mainly Serotonin Reuptake Inhibitors

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Amitriptyline *	Elavil, Endep *	50 - 100 mg	300 mg	Reduce dose for those with renal or hepatic failure	Serious toxicity can result from OD. Slow system clearance. Can cause multiple drug/drug interactions.	Sedation, increased anticholinergic effects, orthostatic hypotension, cardiac conduction disturbances, arrhythmia & wt gain, dizziness, sexual dysfunction.	Response rate = 2 - 4 wks Therapeutic Levels: Imipramine 200-350 ng/mL	Can be given QD. Monitor serum level after one week of treatment.
Imipramine *	Tofranil *	75 mg	300 mg					
Doxepin *	Sinequan *	75 mg	300 mg					
These antidepressants are not recommended for use in the elderly. Highest response rates. TATCAs useful in chronic pain, migraine headaches & insomnia. * Tertiary Amine Tricyclic Antidepressants (TATCAs).								

TRICYCLIC ANTIDEPRESSANTS (TCAs) – Mainly Norepinephrine Reuptake Inhibitors

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Desipramine *	Norpramin *	75 - 200 mg	300 mg	Reduce dose for the elderly & those with renal or hepatic failure	Serious toxicity can result from OD. Reserve Maprotiline as a second-line agent due to risk of seizures at therapeutic & nontherapeutic doses.	Generally Good	Response rate = 2 - 4 wks Therapeutic Levels: Desipramine 125-300 ng/mL Nortriptyline 50-150 ng/mL	Can be given QD. Can start effective dose immediately. Monitor serum level after one week of treatment.
Nortriptyline	Aventyl/Pamelor	50 mg	150 mg					
Consider Desipramine or Nortriptyline first in the elderly if TCAs are necessary. * Secondary Amine Tricyclic Antidepressants (SATCAs)								

I. Strategies for Refractory Depression

- If partial response to one antidepressant, can add tri-iodothyronine (T3), 25-50 micrograms in one daily dose. Baseline T4 or TSH are not predictive of response but useful to monitor TSH suppression during T3 therapy.
- Lithium carbonate, 600-900 mg daily can be added to the existing medication with serum lithium levels monitored
- Trazodone, 50 to 100 mg at night may improve sleep, particularly in conjunction with an SSRI.
- Bupropion may be used with SSRIs, especially for fatigue or sexual dysfunction.
- Anticonvulsants (e.g. carbamazepine) may be added to antidepressants, especially with multiple depressive episodes in one year or prominent impulsivity, irritability or anxiety.
- Change of antidepressant class.
- ECT may be used but should be followed by maintenance treatment with antidepressant or ECT.

J. Guidelines for ECT Use:

1) Indications for ECT

a) Primary ECT may be justified for the following:

- Psychotic features.
- Catatonic stupor
- Severe suicidality
- Food refusal leading to nutritional compromise
- History of good prior response to ECT
- Need for rapid treatment on medical or psychiatric grounds
- Risks of other treatment outweigh risks of ECT
- History of poor drug response
- Patient preference

b) Secondary ECT may be justified for the following:

- Major depression accompanied by either:
  a. Documented antidepressant treatment failure after an adequate trial
  b. Intolerable side effects of antidepressant medication
- Written, Informed consent is required for all ECT

2) ECT is associated with Increased Risk in the following:

- Contraindication = space occupying cerebral lesion or other condition resulting in elevated intracranial pressure.
- Caution = significant cardiovascular problems (recent myocardial infarction, severe cardiac ischemia, profound hypertensive illness).
- Caution = recent intracerebral hemorrhage.
- Caution= degenerative diseases of the axial or appendicular skeleton
- Current use of monoamine oxidase inhibitor medication (MAOI). These should be discontinued 2 weeks prior to ECT.
- Caution = current use of lithium. Lithium and ECT may result in a neurotoxic syndrome.
- High anesthesia risk (ASA level 4 or 5)

K. Criteria for Discharge to a Less Restrictive Setting

- Stabilization and/or improvement of symptoms
- Level of functioning allowing maintenance care in a less restrictive setting
- No acute manifestations of intent to harm self or others
- Support level allows active participation in aftercare